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ABSTRACT

This paper investigates the multicultural demands of health care delivery by examining the role of organizational communication in promoting effective multicultural relations in modern health care systems. The paper describes the multicultural make-up of modern health care systems--noting, for example that providers from different professional cultures (doctors, nurses, pharmacists, nutritionists, etc.) have gone through different education and training programs. The paper also discusses the role of organizational communication (including analysis of the influences of internal and external communication channels, formal and informal message systems, organizational culture, organizational climate, and the processing of equivocal information (K. Weick, 1979) on the organization of health care), and examines some of the primary cultural issues that influence the performance of health care delivery systems. Based upon this review of the role of communication in multicultural health care systems, the paper identifies specific communication strategies which can enable leaders of modern health care delivery systems to promote multicultural cooperation in their organizations. The paper notes that leadership is perhaps the most important factor in promoting effective multicultural relations since leaders exert a powerful influence on organizational culture, providing role models for health care provision and exemplifying how health care staff are supposed to communicate with different consumers. Contains 43 references. (Author/NKA)

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COMMUNICATING IN MULTICULTURAL HEALTH CARE ORGANIZATIONS

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ABSTRACT

This paper investigates the multicultural demands of health care delivery by examining the role of organizational communication in promoting effective multicultural relations in modern health care systems. The paper describes the multicultural make-up of modern health care systems, the role of organizational communication (including analysis of the influences of internal and external communication channels, formal and informal message systems, organizational culture, organizational climate, and the processing of equivocal information (a la Weick) on the organization of health care), and examines some of the primary cultural issues that influence the performance of health care delivery systems. Based upon this review of the role of communication in multicultural health care systems, specific communication strategies are identified to enable leaders of modern health care delivery systems to promote multicultural cooperation in their organizations.

COMMUNICATING IN MULTICULTURAL HEALTH CARE ORGANIZATIONS

The Organization of Modern Health Care

Health care consumers are increasingly dependent upon health care delivery organizations, such as hospitals, clinics, nursing homes, health maintenance organizations (HMOs), and group practices (Starr, 1982). These organizations, as the primary sites for formal health care delivery, are important subsystems within the modern health care system.

Modern health care delivery organizations are often large, complex, and decentralized (having many different departments and divisions, each with distinct missions, functions, and procedures), housing an interdependent mix of differentially trained health care professionals, support staff, and specialized technologies necessary to provide many different health care services to a wide range of consumers (Perrow, 1965; Starr, 1982). Unfortunately, the very complexity of these organizations that enables them to serve a broad range of consumers also makes these modern health care delivery systems increasingly bureaucratic (having many rules and procedures), intimidating, and confusing for many consumers (as well as for providers), significantly limiting the effectiveness of modern health care delivery (Illich, 1976; Kreps, 1990a; 1990b; Mendelsohn, 1979).

The multicultural mix of health care providers and consumers that populate modern health care delivery organizations adds to the complexity of these systems. A major challenge in modern health care is to promote effective multicultural relations between the many different interdependent staff members, providers, and consumers that comprise modern health care delivery organizations.

To accomplish the related goals of health promotion and preservation, health care organizations depend upon cooperation and coordination between

interdependent health care providers, health care administrators, staff members, and consumers to effectively provide health care services (Kreps, 1988). Communication is the essential social process in these health care systems for eliciting cooperation and coordination between interdependent health care providers, consumers and administrators (Ray & Miller, 1990; Costello & Pettegrew, 1979; Kreps & Thornton, 1992). Yet, the communication competencies needed by participants in the modern health care system to elicit necessary coordination for effectively accomplishing health care goals are often very elusive in actual health care practice (Kreps & Query, 1989; Kreps & Thornton, 1992).

Communication and Multicultural Relations

It is not easy to elicit cooperation between interdependent members of health care systems due to culturally-based differences in individual backgrounds, orientations, strategies, and goals. For example, health care providers and consumers, due to their different educational backgrounds and personal orientations, are likely to perceive the same health care situations quite differently and have different expectations for treatment and health outcomes. It is a significant challenge for health care providers and consumers to communicate multiculturally in ways that will promote the sharing of culturally-based health beliefs and expectations, enabling these interdependent participants in the modern health care system to clearly understand one another, ameliorate differences in opinion, and mutually influence each other's behaviors in coordinating health care delivery (Ballard-Reisch, 1993; 1990; Kreps & Thornton, 1992).

The complexity and importance of sharing relevant culturally-based health information in the modern health care system can not be emphasized strongly enough. For example, health care providers and their clients depend on

sharing relevant health information to jointly make important diagnostic and treatment decisions. Yet, due to cultural differences in power, status, and expertise between health care providers and consumers, it is not uncommon for patients to defer to their physicians' judgments about the nature of their ailments and the best way to treat these problems, rather than to participate actively in jointly making decisions about their own health care (Ballard-Reisch, 1993; 1990; .Greenfield, Kaplan, & Ware, 1985; O'Hair, 1986). Due to status differences, patients are often reticent about sharing relevant information concerning their health conditions and experiences with health care providers (Kreps & Thornton, 1992). Furthermore, providers often fail to encourage full patient disclosure and participation, preferring to communicate to patients rather than with patients (Burgoon, Parrott, Burgoon, Birk, Pfau, & Coker, 1987; Greenfield, Kaplan, & Ware, 1985; O'Hair, O'Hair, Southward, & Krayer, 1987; Waitzkin & Stoekle, 1976). The bureaucracy of the modern health care system exacerbates this communication problem by reinforcing status differences and distance between providers and consumers. In this paper we will examine how communication in modern health care delivery organizations can be used to minimize cultural distance between providers and consumers to promote the sharing of relevant cultural information in health care.

Not only is there too much cultural distance between consumers and providers in modern health care, there is often cultural barriers to effective communication between the many specialists, administrators, and other health care professionals that must work together cooperatively in health care delivery organizations. It is often a significant challenge for interdependent health care providers to communicate effectively with one another (establish effective interprofessional relations), especially when

these individuals are members of different (and often competing) professional cultures (Kreps & Thornton, 1992).

Health care providers from different professional cultures usually have gone through different educational and training programs, have different job titles, belong to different professional organizations, and have different health care duties and experiences. Due to differences in their professional training (such as the different educational emphases experienced by surgeons, psychologists, nutritionists, pathologists, pharmacists, internists, and registered nurses) and distinct professional orientations towards health care, different providers are likely to make different decisions about which health care intervention strategies are best for treating a particular consumer's health problems. These differences of clinical judgment are important issues to consider when developing an effective multidisciplinary wholistic treatment (treating the whole person and not just one aspect, such as the pulmonary or respiratory systems, of the person) regimen.

There is very likely to be merit to each of the clinical approaches advocated by the different providers, and a combination of treatment strategies is likely to be warranted. However, without effective multicultural interaction between these interdependent health care providers it is unlikely they will be receptive to sharing and using such relevant treatment information in collaboratively developing the best strategies for patient care. In fact, it is not uncommon for one of these health care providers (usually the one with the highest professional status within the health care system) to ethnocentrically dictate health care treatment decisions without actively consulting other professionals, and in doing so limiting the exchange of relevant diagnostic and clinical health information,

and minimizing the potential for effective wholistic health care treatment (Freidson, 1975).

Effective multicultural relations can help to reduce many of the complexities inherent in modern health care systems by facilitating the exchange of relevant health information, promoting enhanced interprofessional understanding and respect between interdependent members of the health care team (including consumers of health care), and eliciting cooperation and coordination in the delivery of health care services (Kavanaugh & Kennedy, 1992).

Conversely, ineffective multicultural relations in health care organizations inevitably exacerbates the complexity of modern health care by inhibiting the sharing of relevant information, decreasing interpersonal understanding, and alienating interdependent members of the health care system. In this paper we examine many of the challenges to effective multicultural relations in modern organizations, identify several primary issues and settings for multicultural relations in modern health care, and suggest specific strategies for promoting effective multicultural communication in the health care system.

The Role of Communication in Organizing

Human communication is the primary social process that enables human beings to organize (Kreps 1990a). Individuals communicate to establish cooperative interpersonal relationships that are the building blocks of modern organizations. Through communication organization members share relevant information about their expectations for and reactions to each other, developing relational agreements to coordinate their activities in the accomplishment of individual and organizational goals. For example, in health care delivery systems doctors must communicate effectively with their patients

to establish cooperative provider/consumer relationships, gather relevant diagnostic information, and provide clear and persuasive directions for treatment.

Organizational communication is complex, since it encompasses multiple levels of communication (intrapersonal communication, interpersonal communication, interpersonal communication, and group communication). Organizational communication also goes beyond the intrapersonal, interpersonal, and group levels of interaction, including intergroup relations (communication between representatives of different groups) and interorganizational relations (communication between representatives of different related organizations).

Communication is used to coordinate activities at these multiple organizational levels. It is used both internally to facilitate cooperation between members of the same organizations and externally to elicit cooperation between representatives of different organizations. Within the health care system, for example, communication is used to elicit cooperation between health care consumers and their providers, between members of health care teams, between representatives of different hospital departments, and even between an incredibly broad range of different health care delivery and support organizations (such as health care equipment and supply companies, insurance companies, food service companies, volunteer organizations, charitable organizations, relief organizations, public media organizations, consumer groups, accrediting boards, employment agencies, external consultants, and government agencies).

Internal and External Organizational Communication

There are two primary interdependent channels of organizational communication. internal channels of communication and external channels of

communication (Kreps 1990a). Internal communication occurs between members of the same organization. It is referred to as internal communication because it occurs within the boundaries of a single organization. Internal communication is used to perform important administrative functions such as providing job instructions, directing task accomplishment, and providing performance evaluation.

External communication occurs between members of an organization and individuals who are not part of that organization, often with individuals who are representatives of groups within the organization's relevant environment. An organization's relevant environment is composed of all the individuals, groups, and organizations that influence and are influenced by the organization, including potential clients, suppliers, regulatory agencies, competing organizations, and media representatives. External communication is referred to as "external" because it involves the exchange of messages beyond the boundaries of the organization. External communication is used to establish good public relations with members of the relevant environment by both providing these external publics with relevant information (such as annual reports, health education publications, press releases, or advertisements), and by gathering information about external issues of relevance to the organization, and promoting coordination between the organization and key members of its relevant environment.

Multicultural relations dramatically influences the quality of both internal and external communication in the modern health care system. Internal communication in health care involves coordinating the activities of an increasingly diverse population of organizational members. The full gamut of cultural diversity based on nationality, ethnicity, age, gender, education,

profession, socioeconomic status, health status, etc. are evident in modern health care.

Interprofessional cooperation is a particularly critical issue in the provision of health care services. Yet, as we have discussed earlier, cultural barriers and ethnocentrism often impedes cooperation between health care providers representing different specialties and professional groups. Cultural distance between the providers of health care and consumers of health care can limit the effectiveness of multicultural relations in health care, seriously impeding the exchange of relevant information and the development of cooperative provider/consumer relationships. Multicultural sensitivity must be promoted in health care organizations if internal channels of communication are to be effective.

Multicultural relations also influence the quality of external organizational communication in health care delivery organizations. Modern health care delivery organizations serve a very diverse public, including a broad range of different potential consumers, government agencies, regulatory groups, unions, medical supply companies, insurance companies, and benefactors. Health care organizations must tailor their external communication efforts to match the specific cultural perspectives of these different external audiences. No one generic message strategy is likely to satisfy the broad diversity of different publics that comprise the relevant environments of modern health care delivery organizations.

For external communication to be effective, representatives of health care organizations must first identify the relevant publics they need to communicate with, segment these publics into specific (relatively homogenous) audiences, gather relevant cultural information from each of these audiences to identify their culturally-based information needs and orientations

(audience analysis), and then develop culturally sensitive communication strategies for providing these groups with relevant health information, meeting these audiences needs and expectations, and initiating cooperative external relationships. For example, hospitals often engage in external communication campaigns to raise funds, soliciting public financial support through individual and corporate donations. No one fund raising message strategy will work equally well with all audiences. Different message strategies must be used to encourage different potential donors to support the organization. One potential donor may be most interested in the hospital's health risk prevention programs, another potential donor may be more concerned about the availability of the latest health care technologies in the hospital, while a third potential donor may be most interested in the moral values exhibited by the hospital. Successful fund raising campaigns will employ specifically tailored culturally sensitive external messages for each of these potential donors that focus on the specific interests of each of these audiences to encourage their financial support of the hospital.

Balancing Innovation and Stability in Health Care Systems

Effective coordination of internal and external channels of organizational communication enable organizations to maintain an often precarious, yet critically important, balance between innovation and stability in organizational life (Kreps 1990a). Both innovation and stability are important features of organizational life. Innovation is needed to enable organizations to change in response to inevitable constraints and opportunities that emerge over time. Stability is needed to provide structure, stability, and predictability in organizational life.

In health care organizations, for example, internal channels of communication are generally used to prescribe specific job descriptions and

provide training for health care professionals that facilitate coordination between interdependent providers. Similarly, external channels of communication are often used to provide hospital representatives with relevant information, perhaps about new federal regulations for health care, that enable the organization to innovate their activities to meet these new regulations.

Too much stability or innovation can threaten organizational survival. Too much innovation, for example, can make organizational life unpredictable and confusing for organization members, while too much stability can make it difficult for organizations to respond to changing conditions. The challenge of organizing is to effectively balance innovation and stability.

Kreps (1990a) describes the organizational communication strategy of "relative openness" to help organizations maintain a balance between stability and innovation. Relative openness matches organizational use of internal and external communication to the source (internal or external) and extent of information turbulence. Turbulence refers to situations when individuals have difficulty making sense of organizational life, when conditions are uncertain, equivocal, and volatile (Kreps, 1990a; Weick, 1979). Internal turbulence occurs when there are high levels of uncertainty and change within an organization, such as when a company declares bankruptcy and members are not sure whether the organization will survive or whether they will be able to keep their jobs. External turbulence occurs when there are high levels of uncertainty within the relevant environment, such as during natural environmental crises (floods or earthquakes) or during challenging social changes (periods of economic instability, changing government regulations, or even the introduction of powerful new technologies of relevance to the organization).

Relative openness suggests that in response to internal turbulence organizations should restrict communications with the relevant environment and focus attention on the use of internal channels of communication to gather information from organization members about the turbulence they are experiencing and to provide these organization members with relevant information to reduce their uncertainty. In times of external turbulence organizations should be relatively open to their environment, focussing attention on their use of external channels of communication to gather information from and provide relevant information to key external audiences.

Cultural diversity is often a significant challenge to organizational stability, because people who have different cultural orientations are likely to see the world in very different ways and act in accord with different implicit cultural norms. Internal communication must be used in multicultural social systems, like health care delivery organizations, to help make the divergent cultural norms and expectations of culturally diverse populations of organization members explicit, fostering understanding and respect for differences among members. Internal communication can also be used to promote cultural convergence by establishing new organizationally-based cultural norms for guiding coordination among organization members.

In effective health care organizations multicultural communication is used to help culturally diverse organization members develop strategies for cooperation and coordination to promote organizational stability, overcoming the inherent destabilizing tendencies of multiple cultural orientations. Similarly, external channels of organizational communication should be used to promote cooperation between health care organizations and their relevant environments, counteracting the natural culturally-based tendencies diverse publics often have to act idiosyncratically. Organization members can enhance

organizational stability by using internal and external channels of communication to promote cultural convergence, developing shared norms across diverse cultural groups inside and outside of the organization.

While cultural diversity often works against the goal of achieving organizational stability, diversity often has the distinct benefit of enhancing organizational innovation by providing fresh ideas, new solutions to difficult problems, and innovative approaches to organizing. The theory of weak ties explains how people from different cultural backgrounds (weak ties) are likely to provide each other with many new ideas since each cultural group has been socialized to see and cope with the world in very different ways (Liu & Duff, 1972; Granovetter, 1973; Kreps, 1990a; Rogers & Agarwal-Rogers, 1976). The strength of weak ties is that cultural diversity provides organizations with different sources of relevant information and novel strategies for achieving important organizational goals. Health care delivery systems should use internal and external channels of organizational communication to demonstrate respect for and encourage the sharing of culturally diverse ideas and interpretations of organizational reality, encouraging the use of such multicultural interaction in creative problem-solving and innovation generation in organizational life. For example, by establishing a diverse membership in health care teams, ethics committees, and other decision making groups in health care organizations, these groups are likely to generate a broad range of innovative strategies for accomplishing organizational goals.

Formal and Informal Organizational Communication

There are also formal and informal lines of organizational communication. Formal organizational communication follows established organizational hierarchy and structure. They include downward communication messages, sent from superordinates to subordinates to provide job instruction and goal

indoctrination, upward communication, sent from subordinates to superordinates to provide bosses with feedback and to gain support for workers, and horizontal communication, sent between individuals on the same organizational level to facilitate task coordination and social support (Kreps 1990a). Informal organizational communication is not dictated by organizational hierarchy and structure, but develops based upon the natural development of interpersonal relationships between organizational actors. Informal organizational communication is often referred to as gossip or the grapevine, but it serves important information dissemination and social functions for organizational participants.

Formal and informal channels are interdependent. The better the formal organizational channels are at providing organization members with relevant information the less need there is for informal channels. Participants in organizational life have insatiable appetites for relevant organizational information. Yet, the formal channels rarely provide enough relevant information to satisfy this appetite for information. Informal channels of communication arise to provide the inside information that organizational actors desire that is not readily available via the formal communication system. While some personal and political information may not be appropriate for dissemination via formal channels of organizational communication, the informal information system can usually accommodate the most sensitive, personal, and risky information. Unfortunately, informal channels of communication may not always carry the highest quality (full and accurate) information since informal leaders do not always have access to such information.

Interestingly, while informal channels of communication are not mandated and legitimized by the structure of the organization, they have several

advantages over formal channels. They are less likely than formal channels of communication to distort information as it is passed through the organization. Formal channels of communication, especially upward and downward communication, often suffer from serial transmission of information, a one way transmission of messages with little or no feedback which becomes increasingly distorted as the messages are passed from one person to another. As the messages are exchanged up or down the organizational hierarchy the original message becomes more and more distorted due to inadvertent omissions, changes, and additions of relevant information.

Informal channels do not suffer from distortion as much as formal channels because organization members feel free to seek feedback and clarification from informal contacts (usually friends) than they are from formal contacts (often bosses or subordinates), there are often multiple sources of information in informal channels (with particularly "juicy" information spreading like wildfire from many informal sources), and organizational actors often pay more attention to informal channels (which often carry "juicy" information) than they do to formal channels. When formal and informal channels do contradict each other, organization members are more likely to believe informal information sources than formal sources. In the best organizations, leaders attempt to coordinate the use of formal and informal channels of communication, so they complement each other, rather than contradict one another (Kreps 1990a).

Organizational Culture and Multicultural Relations

Every organization develops it own unique cultural identity, often referred to as its corporate culture or organizational culture. Organizational culture refers to the collectively held beliefs, values, and interpretive logics that organization members use to make sense of and respond to diverse phenomena.

Just as in national, ethnic, and professional cultures, organizational cultures establish norms for member behaviors and influence the ways members see the world.

System-wide organizational cultures are comprised of many subcultures. These subcultures often are constituted of several different cultural groups represented in the organization, such as groups composed of members who have similar educational backgrounds (holding the same M.B.A., Ph.D., M.D., or R.N. degrees), members who work in the same functional area of the organization (accounting, surgery, pediatrics, or housekeeping), members who share the same racial, ethnic, or socioeconomic backgrounds, as well as members who may share similar activities (bowling league, executives club, or commuters).

Each subculture within the organizational culture represents a unique set of norms that dictate member beliefs, attitudes, and values. Every subculture has its own identity and has its own relative status within the organization. The organizational status of subcultures change as the organization's political landscape evolves. At any given point in time some subcultures are more influential in the organization than other subcultures. Members of organizational subcultures often jockey for power and position within the organizational political structure, using communication as a primary political tool (Kreps 1990a).

Political struggle is a common phenomenon in many organizations, where different subcultures compete for status and influence. In health care delivery organizations, subcultural competition can be clearly seen in strained interprofessional relations among health care providers and even in opposition between representatives of different departments. For example, members of a hospital Pediatrics Department may feel antagonistic toward members of the Departments of Obstetrics or Surgery since they are socialized

to believe they are in direct competition with these departments for limited equipment, supplies, or personnel resources Cultural ethnocentrism can lead to interdepartmental (and interprofessional) antagonism because the members of one subculture underestimate the legitimacy of other subcultures' claims for resources, while overestimating the validity of their own resource demands. Such culturally-based antagonisms are created by ineffective multicultural relations and can undermine interdepartmental cooperation in hospitals and health care centers that is so necessary for effective health care delivery.

Effective multicultural communication can be used to offset this tendency for ethnocentrism and subcultural competition in health care organizations. Since the organization-wide culture establishes norms for guiding competition between subcultures and helps create a climate for organizational receptivity to different cultural groups, communication can be used to guide the development of norms that promote multicultural receptivity and sensitivity. Organizational cultures, just like other cultures, are created and sustained through organizational communication. Metacommunicative messages (messages that provide feedback about the acceptability of previous communication strategies) can be used to establish norms that encourage members to respect one another (Kreps 1990a). By providing continuous unanimous support to members for communicating in ways that demonstrate respect for cultural diversity, metacommunication can be used to enhance the normative structures of organizational cultures and promote effective multicultural relations in health care organizations (Kreps, 1993a).

Communication Climates in Organizations

Communication climate (the emotional tone present within the organization) has a major influence on subcultural cooperation in organizational life. Just as the actual weather we encounter outdoors every day (hot, cold, rainy,

snowy, or sunny) influences how we feel and behave, the communication climate within an organization (whether it is tense, confrontative, or relaxed) influences the ways organization members feel and behave.

Jack Gibb (1961) describes communication climates as ranging from being supportive to defensive. Supportive climates are ones where organization members feel comfortable interacting and working with one another, fostering both collaboration and trust (Kreps & Thornton, 1992). The more supportive organizational climates are the more likely organization members are to feel comfortable with other members and respect different cultural perspectives represented within the organization. Supportive climates encourage cooperation among organizational subcultures.

In defensive communication climates organization members feel uncomfortable with one another, are not disposed toward sharing relevant information, and are suspicious of one another. Defensive climates discourage cooperation and diminish the effectiveness of multicultural relations. "In health care, defensive climates are often characterized by blaming, time constraints, and a hierarchy that does not take individuals into consideration. They are judgmental, manipulative, emotionally neutral, and dogmatic. Unfortunately, most health related settings are defensive ones" (Kreps & Thornton, 1992, p. 69).

Communication climates are created by the kinds of communication behaviors and strategies used in organizational life. Gibb (1961) suggests that the more organizational actors communicate in ways that are cooperative, nonjudgmental, descriptive, candid, egalitarian, and flexible the more likely they are to establish supportive organizational communication climates. Conversely, the more likely organizational actors are to communicate in ways that are overly critical, dominating, pre-planned, uncaring, superior, and

dogmatic the more likely they are to establish defensive organizational climates. Since supportive communication climates promote effective multicultural relations in health care organizations, it is important for those involved in the health care enterprise to engage in supportive communicative behaviors and strategies as often as possible.

Weick's Model of Organizing and Cultural Diversity

Karl Weick (1979) in his model of organizing refers to the different situations and events that organizational actors encounter as information inputs, emphasizing the importance of information in organizational life. In fact, he suggests the primary reason for organizing is to provide individuals with support and feedback in responding to highly equivocal situations (information inputs). Thus communication plays an important role in social organizing, by helping organizational actors cope with the challenges of interpreting and responding to equivocal information inputs.

Weick (1979) describes organizational environments as information environments. That is, the most salient feature of any organizational environment is the information value of the different situations (information inputs) organizational actors encounter. When organizational actors effectively interpret and respond to the many different information inputs they attend to (selected from the enormous population of potential information inputs that are available in organizational life) they are able to make sense of organizational life and direct the accomplishment of individual and collective goals.

Equivocality refers to the relative level of complexity, lack of predictability, and ambiguity one has in responding to a particular event (Kreps 1990a). Highly equivocal phenomena are very challenging, since they are difficult to understand (Weick, 1979). Yet, organization members have

insatiable appetites for meaning and strive to resolve high equivocality by making sense out of challenging information inputs such as cultural diversity.

Interestingly, equivocality is not merely a characteristic of an event (or information input), but rather, a characteristic of the individual's ability to perceive and respond to the event. That is, a situation is not inherently imbued with a certain level of equivocality. A situation that is of very high equivocality to one person, may be quite simple for another person. It is the ability of the individual to effectively interpret a phenomenon that determines its level of equivocality. Therefore, multicultural relations may now be a very equivocal phenomenon for many organizational actors, but with some communication experience, training, and skill-building, the equivocality of multicultural relations can be reduced.

A primary goal in organizational life is to develop the ability (communicative processes) and interpretive resources (organizational intelligence) to enable organizational actors to interpret and respond effectively to a broad range of information inputs. In hospitals, for example, it is imperative that health care providers respond appropriately to the broad range of health problems presented by the many different consumers who seek health care. Hospitals develop organizational intelligence (policies, procedures, and strategies), based upon past organizing experiences, to guide individualized health care treatment for the many different consumers seeking care.

Organizational actors, like all human beings, have an insatiable appetite for meaning, for understanding the many different people and events they encounter every day (Kreps 1990a). Some of these events (highly equivocal information inputs) challenge their ability to interpret and respond to information inputs, thus challenging their ability to be in control and make

sense of their organizational environments. Weick (1979) contends that organizational actors use two primary communicative responses to make senses of different information situations encountered, the use of rules and cycles.

Rules are pre-established organizational strategies for directing organizational responses to different frequently encountered situations, such as the use of form letters to respond to recurrent information requests or the use of organizational guidelines and policies to guide the accomplishment of specific routine tasks. Cycles are the use of patterns of interlocked communication behaviors organizational actors engage in for processing information inputs to make sense of different organizational situations. Cycles include problem-solving interaction between members of decision making groups, the asking and receiving of advice and counsel, or merely consulting different reference sources to make sense of difficult situations.

The appropriate use of rules and cycles to response to situations of differing levels of equivocality is explained by the principle of requisite variety which suggests that for organizing to be effective, the level of equivocality of any information situation encountered by the organization must be matched by the equivocality of the responses the organization composes to react to the situations. That is, the more complex the situation is, the more complex the response to that situation should be (and also the corollary principle that the less complex the situation is, the less complex the response should be).

Rules are generally less equivocal for organizational actors than cycles are. Rules are of low equivocality for organization members because they are pre-established and provide the actors with specific guidelines for responding to different organizational situations. Cycles are more complex and uncertain than rules because they are more emergent and evolutionary. It is uncertain

how a communicative interaction will transpire and what kinds of responses organizational actors will get to different queries.

Rules are designed to help organizational actors respond to routine situations. They are not very helpful for responding to highly equivocal situations since the situations are too complex and idiosyncratic to be covered by pre-set rules. This is the reason why the overuse of bureaucratic rules and policies is often exacerbates problems, miring already complex organizational situations in a sea of red-tape.

Communication cycles are best suited to help organizational actors respond to highly equivocal situations. Each communication cycle removes some equivocality from a complex information situation. Eventually communication cycles help organizational actors to reduce enough of the equivocality from these complex situations to enable them to develop new rules and use these rules for guiding organizational responses to these situations. Therefore communication is the essential process in organizing. It is only through the use of communication cycles that the equivocality that makes complex organizational situations so difficult to respond to can be reduced, demystifying formerly complex organizational inputs into situations where rules can be established and used.

Since issues concerning cultural diversity in modern health care often challenge organizational actors' abilities to interpret, predict, and control organizational life, multicultural relations in health care is often a highly equivocal organizational problem. According to Weick's model of organizing and the principle of requisite variety the best way to respond to the complexities of multicultural relations in health care is to encourage organizational actors to engage in communication cycles to help them reduce the equivocality they experience to a manageable enough level that rules can

be developed and used. We advocate the development of communication strategies, structures, and media in modern health care delivery systems to address and demystify the equivocality of multiculturalism for participants in the health care system. Conferences, workshops, training sessions, public lectures, discussion groups, ethics committee meetings, and the use of written and audio-visual educational materials concerning multicultural sensitivity and cooperation are examples of communication activities that can serve as effective communication cycles for reducing the equivocality many members of the health care community (health care providers, administrators, consumers and their loved ones) experience when interacting in culturally diverse health care situations.

Communication and Leadership in Multicultural Health Care Systems

Leadership is perhaps the most important factor in promoting effective multicultural relations since leaders have a powerful influence on organizational culture. Leadership communication practices set the tone for cultural sensitivity in organizations. Does organizational leadership demonstrate through their communication that they value cultural diversity? Do they encourage others to respect cultural diversity? Have they established any specific programs, structures, or policies for promoting cultural diversity in their organizations? The answers to these questions will go a long way in explaining the relative quality of multicultural relations in health care delivery organizations.

Leaders in health care delivery organizations provide important role models for health care provision. They exemplify how health care staff are supposed to communicate with different consumers. This is especially important in demonstrating how staff should interact with consumers that have often received prejudicial treatment in health care, such as people with AIDS

(Johnson & Hopkins, 1990; Lambert, 1991; Mondragon, Kirkman-Liff, & Schneller, 1991; Strauss, Fagerhaugh, Suczek, & Weiner, 1991; Treichler, 1987; 1988), the poor (Kosa & Zola, 1975), minorities (Hoppe & Heller, 1975; Martiney, 1978; Quesada & Heller, 1977; White, 1974), women (Chesler, 1972; Corea, 1977; Mendelsohn, 1981), and the elderly (Kreps, 1986; 1990b; Mendelson, 1974; Unites States Senate Special Committee on Aging, 1974; 1975). For example, Kreps (1986) identifies five primary interrelated health communication problems confronting the elderly in seeking health care: "1) their loss of social status within the health care system; 2) their loss of personal independence and control over their health care treatment; 3) limitations in the availability of health care services to the aged; 4) the growing alienation, loneliness, and boredom of the elderly within the health care system; and 5) the increase in fraud and misrepresentation in health care for the elderly" (p. 56). Leaders can help overcome these problems by communicating their respect for elderly health care consumers and their commitment to providing them with the best possible health care services. They can also institute specific policies and training programs to promote sensitive and effective health care for all consumers.

Leadership communication strongly influences the development of both organizational cultures and communication climates. Charismatic leaders (engaging leaders that dramatically communicate a vision of organizational life that followers believe in, establish and communicate clear organizational values and goals that become norms within organizational cultures. Leaders that make it clear that they value cultural diversity and will not tolerate prejudicial and ethnocentric communication in their organizations enhance multicultural relations by setting recognizable standards for multicultural communication. Additionally, by communicating in a caring and sensitive

manner with organization members leaders can help establish supportive communication climates that discourage cultural competition and encourage cooperation.

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